

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01783

Reg. Dist. No. 131

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>						
3. NAME OF DECEASED (Type or print) <b>WILLIAM HOLLAND BEAME</b>		First <b>WILLIAM</b>	Middle <b>HOLLAND</b>	Last <b>BEAME</b>	4. DATE OF DEATH <b>ANDERS S.</b>	Month <b>February</b>	Day <b>19</b>	Year <b>19 57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>62</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>National Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Cleveland Anders</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Beame</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-03-1826</b>		17. INFORMANT <b>Mrs. Margaret L. Anders, Frederick, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO <b>Hemorrhage of lung from gun shot of wound left lung -</b> 28 hours		
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>  ACTUAL SIGNATURE <i>B. O. Thomas</i> DATE SIGNED <i>2/20/1957</i> EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas Sr.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>M.R. Etchison &amp; Son, Frederick, Maryland</b>			24a. REC'D BY REGISTRAR <b>Eligabeth G. Heck</b>			24b. REGISTRAR'S SIGNATURE		
VS. A15ME(5) 5M 9/55			DATE <b>23 Feb 1957</b>					

BUREAU Y. 8  
REGELY ED

FEB 25 1957

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**1720 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 131 01784

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission]				
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Frederick		c. LENGTH OF STAY IN 1b Years		a. STATE Maryland b. COUNTY Frederick				
d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address] 462 West South Street				c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Frederick				
3. NAME OF DECEASED (Type or print)		First LESTER	Middle BURDETTE	Last BARTLETT	4. DATE OF DEATH February 4, 1957	Month February	Day 4	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 13 Feb 1881	9. AGE [In years last birthday] 75 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	-------------------------------------

13. FATHER'S NAME John Bartlett	14. MOTHER'S MAIDEN NAME Alice Compher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Ethel L. Bartlett (Same as item #1)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH Minutes</span>		
DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> <span style="float: right;">Year</span>		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--	--

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
--	--	--	--	--	--

ACTUAL SIGNATURE EXAMINER'S NAME (Type)	James B. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 2/6/57
James B. Thomas, M. D.				

22a. BURIAL, CREMATION, OR REMAINT (Specify) Burial	22b. DATE THEREOF 7 Feb 1957	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland
---	---------------------------------	---	--

23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE 8 Feb 1957	24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck
---	---------	--	---

BUREAU Y.

FEB 11 1957

REGELIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1796 CERTIFICATE OF DEATH

01785

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#5</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Braddock</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VIRGINIA</b>		First <b>SMITH</b>	Middle <b>BRANDENBURG</b>
4. DATE OF DEATH <b>February 17, 1957</b>		Month <b>February</b>	Doy <b>17</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>August 19, 1902</b>		9. AGE (In years at birthday) <b>54</b>	IF UNDER 1 YEAR Months <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Howard Luther Smith</b>	
14. MOTHER'S MAIDEN NAME <b>Leona Thomas</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. J. Harry Brandenburg, Frederick, R.D.#5, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). <b>Hepatonec</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> Not while p. m. <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December, 1957</b> to <b>2/17, 1957</b> that I last saw the deceased alive on <b>2/16, 1957</b> , and that death occurred at <b>6:10A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg., Frederick, Md.</b> DATE SIGNED <b>2/19/57</b>			
ACTUAL SIGNATURE <b>James B. Thomas</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 19, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>2/20/57</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heib</b>	

RECEIVED  
FEB 21 1957

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1797

## CERTIFICATE OF DEATH

01786

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Frederick</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Frederick</b>		d. STREET ADDRESS <b>Frederick County Home</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>VICTOR</b>	Middle <b>BROOKY</b>	Last <b>BROOKY</b>	4. DATE OF DEATH <b>February 2 1957</b>	Month <b>February</b>	Day <b>2</b>	Year <b>1957</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>12-5-1879</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Peter Brooke</b>		14. MOTHER'S MAIDEN NAME <b>Ellen V. Ford</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Albert A. Kennedy-Sr. (Nephew)</b>		Address <b>1804 Woodside Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>24IX</b> DUE TO Condition, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<i>Chronic myocarditis</i>		<i>Brachial Asthma</i>		INTERVAL BETWEEN ONSET AND DEATH <b>11-7-57</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick</b>		(County) <b>Frederick</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from olive on <b>Feb 7</b> , 1957, and that death occurred at 3 A.M.		<b>Feb 1, 1957</b> that I last saw the deceased						M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 N. Market St.-Frederick-Md.</b>	
ACTUAL SIGNATURE <b>H.F. Kline</b>								DATE SIGNED <b>2-4-1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. H.F. Kline-Sr.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-5-1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Johns Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Kline &amp; Son</b>		W. ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR <b>Eliz. G. Heck</b>		24b. REGISTRAR'S SIGNATURE <b>Eliz. G. Heck</b>			
VS A15 (4) 15M 9/55		DR		DATE <b>5 Feb 1957</b>					

OPTIONAL FORM NO. 10  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27

BUREAU X. S.

FEB 7 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01787

131

1771

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
Frederick		a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN TB	b. COUNTY Frederick						
Frederick	24 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Frederick Memorial	Thurmont							
69	3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	William	R		Carty	Feb	2	1957	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. IF UNDER 24 HRS. Min.
M	W			2/24/86	70 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired Mech.		Potomac Edison Co.		Maryland		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S M AIDEN NAME		Address				
Cornelius Carty		Josephine D. Fralcy						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		
no		214-10-5964		Howard F. Carty, Thurmont, Md.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Pulmonary edema DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Bronchopneumonia, bilateral DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		
						INTERVAL BETWEEN ONSET AND DEATH 6 hr		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		
alive on _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		
ACTUAL SIGNATURE		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		
PHYSICIAN'S NAME (Type)		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		21. I certify that I attended the deceased from _____		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
Burial		Feb. 4, 1957		Lewistown M.E.		Lewistown, Fred. Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE		
Reynolds Creagor		Thurmont, Md.		FEB 5 1957		Ely G. Hickey		

11. **ANSWER**—STASH TO THE HAMMERSMITH STATION ON THE DISTRICT LINE.

BUREAU V. 2

FEb 5 1957

REGELY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G.12 3-29-57 et

01788

1772

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>828A North Market Street</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>828A North Market Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARY</b>		(Also Known As Mollie Catherine Clem) <b>CATHERINE</b>		4. DATE OF DEATH <b>February 21, 1957</b>		Month <b>February</b>	Day <b>21</b>	Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1875</b>		9. AGE (In years from birthday) <b>81</b>			
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		September 23, 1875		IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>John H. Clem</b>		14. MOTHER'S MAIDEN NAME <b>Wilhemenia Stull</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Walter G.H.Clem Sr., Frederick, Md.</b>		828A N. Market St., Frederick, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332n</b>		DUE TO <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 1, 1950</b> , to <b>Feb. 21, 1957</b> , that I last saw the deceased alive on <b>Feb. 20, 1957</b> , and that death occurred at <b>4:20A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>M.D. Professional Bldg., Frederick, Md.</b>				DATE SIGNED <b>2/22/57</b>							
ACTUAL SIGNATURE <b>B. O. Thomas Jr.</b>											
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas Jr.</b>		Sa, as above									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Utica Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick County, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>22 Feb 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Eliza B. G. Heck</b>					

RECEIVED

FEB 25 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01789

1798

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Doubs</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>X</b>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CLAUDE</b>		First <b>OSCAR</b>	Middle <b>COOLEY</b>
4. DATE OF DEATH <b>February 4, 1957</b>		Month <b>February</b>	Day <b>4</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>August 12, 1874</b>		9. AGE (In years less birthday) <b>82</b>	10. IF UNDER 1 YEAR Months <b>82</b> Days <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	13. CITIZEN OF WHAT COUNTRY/ <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Cleaning</b>	14. MOTHER'S MAIDEN NAME <b>Mattie Johnson</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Mary Ellen Martin Cooley, Doubs, Maryland</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b)  (c)		<b>1.020.1</b> <b>Urinary Arteritis</b>  <b>Urinary Sclerosis</b>  <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-1</b> , 19 <b>56</b> , to <b>2-4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2-4</b> , 19 <b>57</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. All Saints St., Frederick, Md.</b> DATE SIGNED <b>2/6/57</b>	
ACTUAL SIGNATURE <b>U. G. Bourne Jr.</b>		PHYSICIAN'S NAME (Type) <b>Dr. U. G. Bourne Jr.</b> Same as above	
22a. BURIAL, Cremation, REMAINS (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 7, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>
22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 8 Feb 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Elizabeth L. Hecks</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 and 3 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

FEB 11 1967

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01790

1773

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>Rose Hill Manor</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rose Hill Manor</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JAMES</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Oct 1896</b>	9. AGE (In years last birthday) <b>60</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Realtor &amp; Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Noah E. Cramer</b>		14. MOTHER'S MAIDEN NAME <b>Ella Kate Houck</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WVI</b>		17. INFORMANT <b>Mrs. Katherine L. Cramer</b> (Same as item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Anteroviolent Heart Disease with</i>						INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>acute congestive failure</i>				8 hrs		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Sept 26, 1952, 1a. Dec 15-16, 1956, 8:50A M.</i>						
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4 E. Church St., Frederick, Md.</i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Sept 26, 1952, 1a. Dec 15-16, 1956</b> that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>8:50A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St., Frederick, Md.</b> DATE SIGNED <b>2-16-57</b>								
ACTUAL SIGNATURE <i>Henry V. Chase</i>								
PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>18 Feb 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>19 Feb 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth H. Heck</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-trait permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

FEB 21 1957

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## 1799 CERTIFICATE OF DEATH

11791  
138

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Evansville</i>		c. LENGTH OF STAY IN 1b <i>10 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Same</i>		d. STREET ADDRESS <i>1 Same</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Musseter Road.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Frederick Eugene Crockett</i>		First	Middle	Last	4. DATE OF DEATH <i>February 4 1957</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>October 4, 1884</i>	9. AGE (In years lost birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>James Gleaves Crockett</i>		14. MOTHER'S MAIDEN NAME <i>Ina Crockett</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>1913-219-10-5101</i>		17. INFORMANT <i>Mrs. Marie Crockett</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Hemorrhage (Unknown cause)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>						
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) Arteriosclerotic Heart Disease</i>		DUE TO <i>10 years</i>						
		DUE TO <i>(c) Generalized Arteriosclerosis</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Jan. 23, 1957</i> , to <i>Feb. 1957</i> , that I last saw the deceased alive on <i>Jan. 30, 1957</i> , and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>W.B. Culwell</i> PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>		ADDRESS (Street, city or town, state) <i>Mount Airy, Maryland</i> DATE SIGNED <i>2/4/57</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>5 Feb 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Maryland</i>		22d. LOCATION (City, town, or county) <i>Wytheville, Virginia</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison &amp; Son, Frederick, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>FEB 6-57</i>		24b. REGISTRAR'S SIGNATURE <i>Lucian J. Yalcosan</i>		

RECEIVED

TEB 7 1957

BUREAU V. E.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01792

1800

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 2 should be filed with the funeral director.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 16 <b>15 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		d. STREET ADDRESS <b>11</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emergency Hospital</b>				d. STREET ADDRESS <b>11</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Samuel</b>	Middle <b>L.</b>	Last <b>Crone</b>	4. DATE OF DEATH <b>2</b>	Month <b>2</b>	Day <b>2</b>	Year <b>19 57</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/25/1884</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nightman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ice cream plant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Charles M. Crone</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Biser</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-16-0029</b>		17. INFORMANT <b>Mrs. Nellie Crone, Middletown, Md.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Acute arterial occlusion left leg c</i>				<i>2 days</i>			
DUE TO <i>Gangrene</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		<i>Generalized arteriosclerosis</i>							
DUE TO <i>Gangrene</i>									
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Middleton</b>	(County) <b>Md.</b>	(State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>7/8</b> , 1952, to <b>Sept 1</b> , 1957, that I last saw the deceased alive on <b>Sept 1</b> , 1957, and that death occurred at <b>b P</b> , M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>Middleton, Md.</b>	DATE SIGNED <b>2/4/57</b>
ACTUAL SIGNATURE <i>Kenneth C. Henson</i>	PHYSICIAN'S NAME (Type) <b>Dr. Kenneth Henson</b>	Liddletown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/5/1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) <b>Middleton, Md.</b>	(State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co., Middletown, Md.</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>Elig. H. Heck</b>	24b. REGISTRAR'S SIGNATURE					
			DATE <b>5 Feb. 1957</b>						

PIREAU Y. G.

FEB. 7 1957

REGEV

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01793

1801

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY  Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen	
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Michael		First J.	Middle Crusoe
4. DATE OF DEATH February 13 1957		Month	Day
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 5, 1889		9. AGE (In years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant		10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown	
16. SOCIAL SECURITY NO. 217-09-9957		17. INFORMANT Personnel Records, Victor Cullen St. Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u>		INTERVAL BETWEEN ONSET AND DEATH 5 mins.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u>		32 days	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 14, 1957</u> , to <u>February 13, 1957</u> , that I last saw the deceased alive on <u>February 12, 1957</u> , and that death occurred at <u>7:00 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>I. B. Lyon</u>		DATE SIGNED Feb. 13, 1957	
PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) 2-18-57	
22b. DATE THEREOF 2-18-57		22c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cem.	
22d. LOCATION (City, town, or county) Baltimore Cem.		23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. George</u>	
24a. REC'D BY REGISTRAR DATE 2/13/57		24b. REGISTRAR'S SIGNATURE <u>I. B. Lyon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3. A. 2



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01794

1774

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>24 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. airy</b>		d. STREET ADDRESS <b>RFD I</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Colonel Albert Davis</b>		First	Middle	Last	4. DATE OF DEATH <b>Feb. 7 1957</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1911</b>	9. AGE (in years last birthday) <b>45 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>217-12-2856</b>		11. BIRTHPLACE (State or foreign country) <b>New Market</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
13. FATHER'S NAME <b>John Albert Davis</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Ann James</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-12-2856</b>		17. INFORMANT <b>Sister RUTH JACKSON</b>		Address <b>Mouravia, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <b>Acute congestive heart failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <b>Broncho pneumonia</b>				3 days		
		(c) <b>Marked Obesity</b>				Several Years		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Feb. 5, 1957</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>Feb. 6 1957</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Feb. 6, 1957</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Feb. 5, 1957</b> to <b>Feb. 6, 1957</b> , that I last saw the deceased alive on <b>Feb. 6, 1957</b> , and that death occurred at <b>IA</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>New Market, Md.</b>		DATE SIGNED <b>12 Feb 1957</b>						
ACTUAL PHYSICIAN'S NAME (Type) <b>Ralph L. Michels</b>		PHYSICIAN'S NAME (Type) <b>Ralph L. Michels</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-10-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>SIMPSON'S CHAPEL</b>		22d. LOCATION (City, town, or county) <b>NEW MARKET MD</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>W E Falconer New Market</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE 12 Feb 1957		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>		

J. 22. 1. 1978

مکالمہ

3099

مکالمہ میرا میر

יְהוָה יְהוָה יְהוָה

۱۶۰۰-۱۶۰۱ میلادی

## الطبقة الأولى

224 1921F 600

131965

23 85 111 318 21 53 136 A 116

137. 2  
REVIEWS

14

## הסבב ה-2: מושגים וjęzykowe מושגים

Digitized by srujanika@gmail.com

44-12340 1948, E 10

16. *Merriam's Flocktail* (L.)

136.  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

REGELVÉD

01795

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

#31141

1. PLACE OF DEATH a. COUNTY		1793		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND		a. STATE Maryland b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b		Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH
Male		White	WIDOWED	Divorced	July 31, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None				Brunswick, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John William Dunn		Mary Anne Carey		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)				William J. Nelson Brunswick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion			
460.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Bil Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>Bil Thomas</i>		DATE SIGNED <i>February 10, 1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb. 23, 1957		22c. NAME OF CEMETERY OR CREMATORIAL St. Marys Church Cemetery	
22d. LOCATION (City, town, or county) Petersville		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Dailey</i>		ADDRESS Frederick, Md. DAILEY'S FUNERAL HOME 1201 N. Market St.		24a. REC'D BY REGISTRAR DATE 23 Feb 1957	
				24b. REGISTRAR'S SIGNATURE <i>Eugenia Burley</i>	

PUT MEDICAL EXAMINER'S SIGNATURE ON THIS CERTIFICATE should be executed within 24 hours of death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the reg. or prior to burial or removal.

BUREAU V.

FEB 25 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1802

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

01796

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN lb Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Nursing Home				d. STREET ADDRESS Braddock Heights		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HOWARD	Middle MARSHALL	Last EIGENBRODE	4. DATE OF DEATH February 17, 1957	Month February	Day 17	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1886	9. AGE (In years from birth day) 70 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Daniel Eigenbrode			14. MOTHER'S MAIDEN NAME Rosilla Matthews				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edna Eyler Eigenbrode, Frederick, RD#5, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Carcinoma of stomach</i> INTERVAL BETWEEN ONSET AND DEATH <i>Month</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Thurmont	(County) Maryland	(State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:15 P.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>James B. Thomas</i> M.D. Professional Bldg., Frederick, Md. 2/18/1957							
PHYSICIAN'S NAME (Type) Dr. James B. Thomas		Same as above					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 19, 1957	22c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cemetery,	22d. LOCATION (City, town, or county) Thurmont		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE 20 Feb 1957	24b. REGISTRAR'S SIGNATURE <i>Elizabeth L. Heck</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use of the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEB 21 1957  
BUREAU X

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1803

## CERTIFICATE OF DEATH

01797

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Thurmont		b. COUNTY	
40 yrs.		Frederick	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Thurmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #2		d. STREET ADDRESS Route # 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
DORA		ELIZABETH	EYLER
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
female		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years from birth) 72 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
March 30, 1884			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Miller		14. MOTHER'S MAIDEN NAME Mary Katherine Kipe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
		17. INFORMANT none Lloyd Eyer, Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 6 years	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
myocardial degeneration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 May 28, 1954</u> , to <u>Feb 6, 1957</u> , that I last saw the deceased alive on <u>Feb 6, 1957</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Emmitsburg, Md</u> DATE SIGNED <u>Feb 7, 1957</u>	
ACTUAL SIGNATURE <u>Charles R. Williams</u> M.D.		22. LOCATION (City, town, or county) <u>Thurmont, Fred C. Md.</u> (State)	
PHYSICIAN'S NAME (Type) <u>CHARLES R. WILLIAMS</u>		23. BURIAL, CREMATION, REMOVAL (Specify) Burial Feb. 10, 1957	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL United Brethren	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		24a. REC'D BY REGISTRAR DATE <u>Feb 11 '57</u> 24b. REGISTRAR'S SIGNATURE <u>W. E. Creager</u>	
ADDRESS <u>Thurmont, Md.</u>			

BUREAU X-6

EEB 11 1957

EEIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1804

## CERTIFICATE OF DEATH

01798  
145-

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Myersville</b>		c. LENGTH OF STAY IN 1b <b>years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ Rural Myersville</b>		d. STREET ADDRESS <b>/</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>OR INSTITUTION</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Keefor I. Fisher</b>		First	Middle	Last	4. DATE OF DEATH <b>2 12 19 57</b>	Month	Day	Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7/9/1909</b>	9. AGE (In years lost birthday) <b>47 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Philin I. Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Jane L. Guilbert</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>220-16-5725</b>		17. INFORMANT <b>Elmard Fisher, Myersville, Md.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1</b>		DUE TO <b>Probable Carcinoma Liver</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Middletown</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <b>E.P.</b> M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>J. Elmer Harp</b>		M.D.		ADDRESS (Street, city or town, state) <b>2-13-57</b>		DATE SIGNED <b>Middletown Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. Elmer Harp</b>		Mid letown,							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/14/1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>U.B. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Myersville, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladiola Co., Middletown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DATE 2-14-1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elroy M. Bittle</b>			

REGULAR V. C

FEB

REGULAR

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1805

## CERTIFICATE OF DEATH

01799  
141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
Frederick MARYLAND		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRUNSWICK	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 509 East Main		d. STREET ADDRESS 509 East Main	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Carrie	Middle Agnes	Last Grams
4. DATE OF DEATH	Month 2	Day 18	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1884
9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Huttons		14. MOTHER'S MAIDEN NAME Emma Kidwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT Le Roy Grams, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mo 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary disease Diabetes Melitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 3 1956</u> to <u>2/18 1957</u> , that I last saw the deceased alive on <u>2/17 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		DATE SIGNED 3/9/57	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 2-20-1957	22c. NAME OF CEMETERY OR CREMATORIUM Park Heights	22d. LOCATION (City, town, or county) (State) Brunswick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Felt		24a. REC'D BY REGISTRAR DATE B 25 1957	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Eugenia Barker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

FEB 23 1967

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01800

## 1775 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived a. STATE <b>Maryland</b> )		If institution Residence before admission b. COUNTY <b>Frederick</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>333 West Patrick Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>												
3. NAME OF DECEASED (Type or print) <b>MORA</b>		First	Middle <b>FANNIE</b>	Sur.	<b>GROVE</b>	4. DATE OF DEATH	Month <b>February</b>	Year <b>27, 1957</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Feb 1882</b>		9. AGE (In years last birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR Months <b>7</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>George W. Phebus</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Fisher</b>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William F. Grove (Same as item #2)</b>		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>441X</b>		<b>Bronchitis pneumonia</b>				<b>7 week</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost		(b) <b>Myocardial Decompression</b>				<b>1 year</b>						
		(c) <b>Pulmonary Edema</b>				<b>1 Day</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <b>Jan 2</b> , 1957, to <b>Feb 27, 1957</b> , that I last saw the deceased alive on <b>Feb 27, 1957</b> , and that death occurred at <b>11:55A M</b> , from the causes and on the date stated above.												
MEDICAL CERTIFICATION						ADDRESS (Street, city or town, state)		DATE SIGNED				
20g. PHYSICIAN'S NAME (Type) <b>H. Lawrence Fahrney, M. D.</b>						<b>M.D. 17 E. 2nd St., Frederick, Md.</b>		<b>2-28-57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>14 March 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>1 March 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heek</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 4 1967

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1806 CERTIFICATE OF DEATH

Reg. Dist. No. 01801 147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Unionville</i>		c. LENGTH OF STAY IN lb <i>1 hr.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Airy</i>	
3. NAME OF DECEASED (Type or print) <i>William Benton Harn</i>		d. STREET ADDRESS <i>50. Main</i>	
4. DATE OF DEATH <i>Feb. 10 1957</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>white</i> <i>2-20-1885</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>store.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Harn</i>		14. MOTHER'S MAIDEN NAME <i>Clementine Long</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <i>213-16-6969</i>	
17. INFORMANT <i>Mrs. Hellie M. Danner, Unionville</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>Immediately more than 2 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Frederick</i> (County) <i>Maryland</i> (State)	
21. I certify that I attended the deceased from <i>Feb. 1, 1953</i> , to <i>Feb. 10, 1957</i> , that I last saw the deceased alive on <i>Feb 1, 1957</i> , and that death occurred at <i>6:10 p.m.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Mount Airy</i> DATE SIGNED <i>2/14/57</i>	
ACTUAL SIGNATURE <i>W.B. Culwell</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>		Md.	
22a. BURIAL, CREMATION, REMOVAL (S) <i>BURIAL</i>		22b. DATE THEREOF <i>2-13-1957</i>	
22c. NAME OF CEMETERY <i>Linganore</i>		22d. LOCATION (City, town, or county) <i>Frederick Co., Maryland</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Waltz,</i>		ADDRESS <i>Winfield, Maryland</i>	
24a. REC'D BY REGISTRAR <i>FEb 13 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Clarence Rankled</i>	

RECEIVED  
1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1807

## CERTIFICATE OF DEATH

01802

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Myersville

c. LENGTH OF STAY IN 1b  
RURAL and give nearest town)

36 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)

a. STATE  
Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Myersville

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATHMonth  
FebruaryDay  
11  
Year  
1957

## 5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (In years  
last birthday)IF UNDER 1 YEAR  
Months  
75  
yrsIF UNDER 24 HRS  
Days  
Hours  
Min.

female white

WIDOWED DIVORCED 

April 10, 1881

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Myersville, Fred. Co. Md. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

Lewis Flook

## 14. MOTHER'S MAIDEN NAME

Margaret Warrenfeltz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

no

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

none

## 17. INFORMANT

Mrs. Ruth DeGrange, Middletown, Md.

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
(IMMEDIATE CAUSE (a))

400.0

DUE TO

Coronary Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

Arteriosclerotic Heart Disease

some

(c)

3 years

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

Diphtheria Mellitus

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
White at work  Nat white at work 20e. PLACE OF INJURY (Name, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 1, 1953, to 11 Feb 1957, that I last saw the deceased  
alive on 11 Feb 1957, and that death occurred at 11 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Thomas E. Stone

M.D. 4 W 3 rd st

PHYSICIAN'S  
NAME (Type)

Thomas E. Stone

STONE 4 East 3rd. St. Frederick, Md.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Feb. 14, 1957

22c. NAME OF CEMETERY OR CREMATORIUM

United Brethren

22d. LOCATION (City, town, or county)

Myersville, Fred. Co.

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Paul E. Bittle

ADDRESS

Myersville, Md.

24a. REC'D BY REGISTRAR

DATE 2/13/57

24b. REGISTRAR'S SIGNATURE

Floyd M. Bittle

SAU V. S.

5 1957



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1808

## CERTIFICATE OF DEATH

01803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Anthony Nr. Emmitsburg</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Anthony Near Emmitsburg</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>George</b>	First <b>Leo</b>	Middle <b>Hemler</b>	4. DATE OF DEATH Month <b>February</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24 1880</b>	
9. AGE (In years to birthday) <b>76</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Frederick Co. MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel A. Hemler</b>	14. MOTHER'S MAIDEN NAME <b>Annie C. Florence</b>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No ne</b>	17. INFORMANT <b>Mrs Felix Hemler</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1X</b> DUE TO Carcinoma of Bladder with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malnutrition</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Malnutrition</b>		
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Emmitsburg</b>	20f. (City or town) <b>Emmitsburg</b>	(County) <b>Frederick Co.</b>
21. I certify that I attended the deceased from <b>Dec. 1956</b> to <b>Feb. 16, 1957</b> , that I last saw the deceased alive on <b>Feb 16, 1957</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles R. Williams M.D.</b> ADDRESS (Street, city or town, state) <b>Emmitsburg, Md</b> DATE SIGNED <b>2-20-57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Anthony Cem.</b>	22d. LOCATION (City, town, or county) <b>St. Anthony</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond S. Greagor Thurmont</b>		ADDRESS <b>Thurmont</b>	24a. REC'D BY REGISTRAR DATE <b>2-22-1957</b>	24b. REGISTRAR'S SIGNATURE <b>L. J. Hedrick</b>

BUREAU V. S.

FEB 25 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01804

## 1809 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick Maryland		Virginia Warren Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
New Rockville	1 year	Happy Creek	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Montauk Road			
3. NAME OF DECEASED (Type or print)		First	Middle
John Newton Henry		John	Newton
4. DATE OF DEATH		Month	Day
February 28 1957		February	28
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	1898
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Cook	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Virginia		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Henry		Mel Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
Yes		230-05-7657	
17. INFORMANT		Address	
Marvin Donald		Front Royal Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Minutes	
400.1		Coronary occlusion	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE		DATE SIGNED	
B. O. Thomas		February 28, 1957	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF	
Burial		3-2-57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) (State)	
Prospect Hill		Front Royal Va	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
B. O. Tutt		Mar 1 1957	
Brunswick, Maryland		Ely - Dick	
VS. ATSM(E5) SM 9/55		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

MAR 4 1967

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01805

1776

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND</b>		b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODSBORO</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print)	First <b>GOLDIE</b>	Middle <b>SNOW</b>	Last <b>HILDEBRAND</b>	4. DATE OF DEATH <b>FEB 24 1957</b>	Month	Day	Year
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> SEPT 26-1883</b>	9. AGE (In years last birthday) <b>73 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ABRAHAM DERN</b>		14. MOTHER'S MAIDEN NAME <b>ANN ELIZABETH REDDICK</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>G.R. HILDEBRAND, Woodsboro, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  <b>Coronary Arteries</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
21. I certify that I attended the deceased from <b>Feb 24 1957</b> to <b>Feb 25 1957</b> that I last saw the deceased alive on <b>Feb 24 1957</b> , and that death occurred at <b>3:25 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>G. R. H. MESSLER, M.D.</b>		22. DATE OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woodsboro, Md.</b>		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. MEDICAL CERTIFICATION		26. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		27. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		28. ADDRESS (Street, city or town, state) <b>Woodsboro, Md.</b>	
29. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL 2/26/57</b>		30. DATE THEREOF <b>2/26/57</b>		31. NAME OF CEMETERY OR CREMATORIUM <b>MT. HOPE CEM.</b>		32. LOCATION (City, town or county) <b>WOODSBORO, MD.</b>	
33. FUNERAL DIRECTOR'S SIGNATURE <b>Powell Hartley, Woodsboro, Md.</b>		34. ADDRESS <b>Powell Hartley, Woodsboro, Md.</b>		35. REC'D BY REGISTRAR DATE <b>2/26/1957</b>		36. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	

TO HOSPITAL  ATTENDANT  PHYSICIAN  The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR  After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3UREAU V. S.

EB 6 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

01806

1777

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>5 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) 3. INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>1701 Rosemont Ave.</b>	
3. NAME OF DECEASED (Type or print)	First <b>ALMFOA</b>	Middle <b>LOUENHA</b>	Last <b>HULVER</b>
4. DATE OF DEATH	Month <b>FEBRUARY</b>	Day <b>12</b>	Year <b>1957</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Oct 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES BRADFIELD</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Lloyd Hulver mt. airy md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Arteriosclerotic Heart Disease</b>		Yrs -	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p. m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) <b>Frederick</b> (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>Jan 1, 1953</b> to <b>12 Feb, 1957</b> , that I last saw the deceased alive on <b>12 Feb, 1957</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 W 3rd St</b> DATE SIGNED <b>2-12-57</b>			
ACTUAL SIGNATURE <b>Thomas E. Stone</b>		PHYSICIAN'S NAME (Type) <b>Thomas E. STONE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 14, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) <b>Mountain Falls, Va.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison</b>		ADDRESS <b>Elmwood Cemetery, Frederick, Md.</b>	
		24a. REC'D BY REGISTRAR <b>Elmer H. Hulse</b>	
		24b. REGISTRAR'S SIGNATURE <b>Elmer H. Hulse</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Loge 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUKEAU V.

1957

NEGATIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1778 CERTIFICATE OF DEATH

01807

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 404 West South Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 404 West South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> EX	
3. NAME OF DECEASED (Type or print)	First MELVIN	Middle IGNATIUS	Last JAMISON	4. DATE OF DEATH	Month February	Doy 27	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 27 June 1889	9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John I. Jamison				14. MOTHER'S MAIDEN NAME Mary Catherine Jamison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-5070		17. INFORMANT Mrs. Dorothy R. Staley, Union Bridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Solar pneumonia, right lung</u> 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from <u>2/23</u> , 1957 to <u>2/27</u> , 1957, that I last saw the deceased alive on <u>2/26</u> , 1957, and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D. <u>4 E. Church St., Frederick, Md.</u> DATE SIGNED <u>2-28-57</u>							
ACTUAL SIGNATURE <u>Henry V. Chase</u>							
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2 March 1957		22c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>March 1957</u>	24b. REGISTRAR'S SIGNATURE Elizabet B. Hesk

BUREAU V.

MAR 4 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01808

1810

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) BRUNSWICK</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) BRUNSWICK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>SAMUEL</b>	Middle <b>NEWTON</b>	Last <b>JOHNSON</b>
4. DATE OF DEATH	Month <b>2</b>	Day <b>12</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-1863</b>
9. AGE (In years last birthday) <b>93</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel N. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address <b>Kenous Johnson, Brunswick, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
794X DUE TO <i>Samuel</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-1957</b> to <b>2-12-1957</b> , that I last saw the deceased alive on <b>2-12-1957</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. E. Pruitt</i>		M.D. <i>B. W. Pruitt, M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-15-57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>McC Milliam</b>		22d. LOCATION (City, town, or county) <b>Briar Hill, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Felt</i>		24a. REC'D BY REGISTRAR DATE <b>2/14/57</b>	
ADDRESS <b>Brunswick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Eugenia L. Felt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2. A. 1944

LEUT



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

01809

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 211 Monroe Avenue	
3. NAME OF DECEASED (Type or print) Ray		First Middle Singleton	Last 4. DATE OF DEATH Feb. 18 Month Day Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20-1900
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John King		14. MOTHER'S MAIDEN NAME Minnie Summers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0664	
17. INFORMANT Mrs. Ray S. King-211 Monroe Ave.-Frederick-Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Final Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 15</u> , 1945, to <u>Feb. 18</u> , 1957, that I last saw the deceased alive on <u>Feb. 18</u> , 1957, and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>H. Laurence Fahrney</u> M.D. ADDRESS (Street, city or town, state) <u>17 E. 2nd. St.-Frederick-Md.</u> DATE SIGNED <u>2-20-57</u>			
PHYSICIAN'S NAME (Type) Dr. H. Laurence Fahrney		Frederick Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 21-1957	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline &amp; Son</u>		W. ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE <u>22 Feb 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heib</u>	

REFEVIEW

FEB 25 1957

BUREAU X

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1811

## CERTIFICATE OF DEATH

Reg. Dist. No.

018191

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Frederick		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Frederick	
3. NAME OF DECEASED (Type or print) THOMAS		First F.	Middle LINTON
4. DATE OF DEATH FEB. 22, 1957		Month Feb.	Day 22
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm laborer		10b. KIND OF BUSINESS OR INDUSTRY farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John T. Linton		14. MOTHER'S MAIDEN NAME Mary Forrest	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Minnie Linton,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 16, 1957</u> , to <u>Feb 22, 1957</u> , that I last saw the deceased alive on <u>Feb 22, 1957</u> , and that death occurred at <u>10:05</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>3110 Roslyn</u> DATE SIGNED <u>Feb 23, 1957</u>	
ACTUAL SIGNATURE <u>John H. Messler</u>		PHYSICIAN'S NAME (Type) John H. Messler	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-25-1957	
22c. NAME OF CEMETERY Pine Grove		22d. LOCATION (City, town, or county) Mt. Airy, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR FEB 25 1957		24b. REGISTRAR'S SIGNATURE <u>Eugie Becka</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please retain carbon papers. Page 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

FEB 25 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**1731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01811

Reg. Dist. No. 141

PLACE OF DEATH a. COUNTY		Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
		MARYLAND		b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		B runswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				Garrots Mills	
c. LENGTH OF STAY IN Tb				d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		In an Automobile		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
D. E. P.				MATHE	2
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male		Col.		3-17-1892	87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Janitor		D. & O. Y. M. C. A.		Pennsylvania	
12. CITIZEN OF WHAT COUNTRY?					
				U.S.A.	
13. FATHER'S NAME		Francis Mathews		14. MOTHER'S MAIDEN NAME	
				Mary Redicar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		World War I		219-07-2549 Mrs. Margie Mathews, Knoxville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		420.1 <i>Conusungulomiasis</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO (b)			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 2/7/57			
ACTUAL SIGNATURE <i>B.C. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>B.C. Thomas</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-57	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley	22d. LOCATION (City, town, or county) Garrots Mills (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE 2/14/57	24b. REGISTRAR'S SIGNATURE <i>Eugene Burke</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. File Pages 1 and 2 with the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for 1 year.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial or removal.

W. V. S.

150

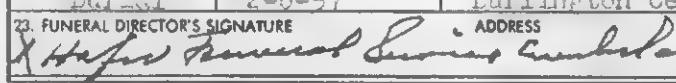


rejoined by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely  
 filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**1812 CERTIFICATE OF DEATH**

01812  
Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>		c. LENGTH OF STAY IN 1b <b>292 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cresaptown</b>	
3. NAME OF DECEASED (Type or print) <b>James</b>		d. STREET ADDRESS <b>/ x</b>	
4. DATE OF DEATH <b>February 5, 1957</b>		5. DATE OF BIRTH <b>December 15, 1889</b>	6. AGE (In years last birthday) <b>67 yrs.</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
9. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Burlington, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George McIntosh</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Cooke</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES [Yes, no, or unknown] <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Deceased</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Silicosis</b>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Burlington</b> (State) <b>W. Va.</b>	
21. I certify that I attended the deceased from <b>April 19, 1956</b> , to <b>February 5, 1957</b> , that I last saw the deceased alive on <b>February 5, 1957</b> , and that death occurred at <b>2335 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cullen, Md.</b> DATE SIGNED <b>February 6, 1957</b>			
ACTUAL SIGNATURE 			
PHYSICIAN'S NAME (Type) <b>I. B. Lyon, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-8-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Burlington Cem.</b>		22d. LOCATION (City, town, or county) <b>Burlington, W. Va.</b> (State) <b>W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE 		24a. ADDRESS ADDRESS DATE 2/5/57	
		24b. REGISTRAR'S SIGNATURE 	

BUREAU V. S.  
KINGMAN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG21 111-167-81

01813

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK LIFETIME		c. LENGTH OF STAY IN b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK, MARYLAND, 11 W. All Saints St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME FOR THE AGED		d. STREET ADDRESS 115 Record St. HOME FOR THE AGED, Frederick	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EFFIE		First	Middle
4. DATE OF DEATH Feb. 13 1957		Last	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 30. 1873
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10b. KIND OF BUSINESS OR INDUSTRY NURSE ING	
10c. BIRTHPLACE (State or foreign country) FREDERICK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS HENRY KOLB		14. MOTHER'S MAIDEN NAME MARGARET CATHERIN MACGRUDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Records: HOME FOR THE AGED.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO (c) Hypertensive heart dis.	
		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital heart dis (?) type embolism	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notation of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <u>13 Feb.</u> 1957, and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE C. H. Conley, M.D.		M.D.	
PHYSICIAN'S NAME (Type) C. H. Conley, M.D.		Professional Bldg, Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 16, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET		22d. LOCATION (City, town, or county) FREDERICK	
23. FUNERAL DIRECTOR'S SIGNATURE H. Conley		24a. REC'D BY REGISTRAR DATE 15 Feb. 1957	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Herk	

REGISTRATION

54-1111

FEB 11 1965

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01814

Reg. Dist. No.

1813

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>		d. STREET ADDRESS <u>1 R.F.D. E</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Roy Robert Messner</u>		First	Middle	Last	4. DATE OF DEATH <u>February 23 1957</u>	Month	Day	Year							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10, 1891</u>		9. AGE (in years last birthday) <u>65 yrs.</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Frederick Co.</u>							
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles J. Messner</u>				14. MOTHER'S MAIDEN NAME <u>Julia Six</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>PI8-09-0054</u>				17. INFORMANT <u>Mrs. Geneva Martin Thurmont, R.D. #1</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Raymond Thurmont</u> DUE TO 420.1 Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>16 months?</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Thurmont</u> (County) <u>Frederick Co.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				22. ACTUAL SIGNATURE <u>B.C. Thomas</u>				DATE SIGNED <u>Feb. 23, 1957</u>							
EXAMINER'S NAME (Type) <u>B.C. Thomas</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb. 25th, 1957</u>				22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>U.B. Cem.</u>				22d. LOCATION (City, town, or county) <u>Thurmont</u> (State) <u>Frederick Co. MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Greager, Thurmont</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 26 1957</u>				24b. REGISTRAR'S SIGNATURE DATE <u>W. French</u>							

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2 and 3 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A1SME(5)  
5M 9/55

BUREAU V.

FEB 00 1937

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

178

## CERTIFICATE OF DEATH

01815  
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md		b. COUNTY		Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Point of Rocks		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Frederick Memorial		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
M		W		Robert		EUGENE	Mohler	Feb	19	1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS	
				1 Aug 53		3 yrs.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Infant		At Home		Md		USA					
13. FATHER'S NAME		Boyd Mohler		14. MOTHER'S MAIDEN NAME		Catherine Hale		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hospital Records			
No		No		None		Meningitis due to		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		(c)		DUE TO					
DUE TO											
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Manh.	Doy.	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)		(State)	
21. I certify that I attended the deceased from		19 Feb		1957	to	19 Feb	1957	ADDRESS (Street, city or town, state)		DATE SIGNED	
alive on		19 Feb		1957	and that death occurred at	12:00	M, from the causes and on the date stated above.	Koch		2/19/57	
ACTUAL SIGNATURE		R. L. Guest		M.D.		T. E. Church st					
PHYSICIAN'S NAME (Type)		R. L. Guest				Frederick		Md			
22a. BURIAL, CREMATION, REMAINS (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Burial		Feb. 22, 1957		Mount Olivet Cemetery		Frederick		Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
M. R. Etchison & Son, Frederick, Maryland				DATE 23 Feb 1957		Elizabeth B. Herb					

RECEIVED  
BUREAU V. S.

FEB 15 1957

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**1814 CERTIFICATE OF DEATH**

01816

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b>		c. LENGTH OF STAY IN 1b <b>62 yrs.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Bertha</b>		First <b>Bertha</b>	Middle <b></b>			
4. DATE OF DEATH <b>Feb. 4 1957</b>		Month <b>Feb.</b>	Day <b>4</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>Oct. 1-1877</b>		9. AGE (In years last birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard Blackston</b>				
14. MOTHER'S MAIDEN NAME <b>Elizabeth Bell</b>		15. IS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. John E. Morningstar (husband) -</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma</b>		Address <b>Buckeystown-Maryland</b>				
15IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Carcinoma</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b></b>	(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from <b>Jan 1 1954</b> to <b>Feb 4 1957</b> , that I last saw the deceased alive on <b>Feb 4 1957</b> , and that death occurred at <b>9:15AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b>B. O. Thomas Jr.</b> M.D. <b>Professional Bldg., Frederick-Md. 2-6-1957</b>						
ACTUAL SIGNATURE						
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas-Jr.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-7-1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick</b> (State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		W. ADDRESS <b>Frederick-Maryland</b>	24a. REC'D BY REGISTRAR DATE <b>8 Feb 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>			

BUREAU V. S.

EB. 11 1952

REGGIE BO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01817

1782

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 16 12 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WALTER	Middle THOMAS	Last MYERS	4. DATE OF DEATH February 7, 1957	Month February	Day 7	Year 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 18 Nov 1891	9. AGE (In years at birthday) 65	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Myers		14. MOTHER'S MAIDEN NAME Rachel Wright						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WVI		17. INFORMANT Mrs. Margaret B. Myers (Same as item #2)		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Bronchogenic carcinoma lung				INTERVAL BETWEEN ONSET AND DEATH 1 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) M.D.		(County)	(State)	
21. I certify that I attended the deceased from <u>Jan 3, 1950</u> to <u>Feb. 7, 1957</u> that I last saw the deceased alive on <u>Feb. 6, 1957</u> , and that death occurred at <u>4:10A</u> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md.		
ACTUAL SIGNATURE <i>Bernard O. Thomas</i>						DATE SIGNED 2-8-57		
PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9 Feb 1957		22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 8/26/1957		24b. REGISTRAR'S SIGNATURE <i>Elizabeth L. Welch</i>		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
it should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BUREAU V. 3

EB 11 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1783

## CERTIFICATE OF DEATH

01818

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hometown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Chester	Middle Willard	Last Neighbours	4. DATE OF DEATH 2	Month 2	Day 21	Year 1957
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/1888	9. AGE (in years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance salesman		10b. KIND OF BUSINESS OR INDUSTRY life insurance		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME William Neighbours		14. MOTHER'S MAIDEN NAME Villa Ramsberg						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 210-10-3171		17. INFORMANT Mrs. Edith Neighbours, Hometown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 days		
		DUE TO Arteriosclerosis						
		(c) Hypertension CV Disease				8 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson's Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/15/1957 to 2/21/1957, that I last saw the deceased alive on 2/20/1957, and that death occurred at 1957 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Dr. A. Talbott Bricc						ADDRESS (Street, city or town, state) Jefferson, Md.		
22a. BURIAL, Cremation, REMOVAL (Specify) 2/23/1957		22b. DATE THEREOF 2/23/1957		22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery		22d. LOCATION (City, town, or county) Hometown, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Glasgow Co., Hometown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 27 Feb 1957		24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEIPZIG V. 8

1957

LEIPZIG

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01819

1784

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine, Md.</b>		c. LENGTH OF STAY IN 1b RURAL, and give nearest town) <b>RURAL - Woodbine</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>FREDERICK MEMORIAL</b>		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>LILY</b>	Middle <b>M.</b>	Last <b>PICKETT</b>
4. DATE OF DEATH <b>FEB 14 1957</b>	Month Year	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1877</b>
9. AGE (In years from birthdate) <b>85 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Reuben Henry</b>	14. MOTHER'S MAIDEN NAME <b>Ann ??</b>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <b>6</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<b>BRONCHOPNEUMONIA</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		35	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL AT HOME</b>	
20c. TIME OF INJURY Hour a.m. p.m. <b>1 - 10 1957</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>	20f. (City or town) <b>WOODBINE</b>
21. I certify that I attended the deceased from <b>1 - 10 1957</b> to <b>2 - 14 1957</b> , that I last saw the deceased alive on <b>2 - 14 1957</b> , and that death occurred at <b>600A</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>John M. Culler</b>		COUNTY <b>Howard</b> (State) <b>MD</b> ADDRESS (Street, city or town, state) <b>15 E SECOND ST</b>	
DATE SIGNED <b>2 - 14 - 57</b>			
22a. BURIAL, CREMATION, OR REMAINTERS (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-18-1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Michaels</b>
22d. LOCATION (City, town, or county) <b>Howard Co., Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>Elizabeth S. Heck</b>	24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>
ADDRESS <b>Winfield, Maryland</b>		DATE <b>18 Feb 1957</b>	

BUREAU V. S.

1957

WILSONVILLE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01820

1785

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
FREDERICK MARYLAND		MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK	
c. LENGTH OF STAY IN 1b 3 Years		d. STREET ADDRESS 116 E. 7 <sup>th</sup> ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LORNA		4. DATE OF DEATH FEB. 26 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-51
9. AGE (in years last birthday) 5 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROYCE O. ROBERTSON		14. MOTHER'S MAIDEN NAME EVELYN MOORE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Royce O. Robertson (Same As Item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO MENINGITIS			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-26, 1957, to 2-26, 1957, that I last saw the deceased alive on 2-26, 1957, and that death occurred at 8:35 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frederick J. Hechler, M.D.</i>		ADDRESS (Street, city or town, state) 220 W. MARKET ST. 2-27-57 DATE SIGNED 2-27-57	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 1 March 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 28 Feb 1957	
		24b. REGISTRAR'S SIGNATURE <i>Elizabeth B. Hechler</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log

may be retained by the hospital or attending physician until the certificate has been signed by the attending physician and completely filled out. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 1 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01821

## 1786 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 46 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 109 East Second Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rosa	Middle M.	Last Roddy	4. DATE OF DEATH Feb.	Month 25	Day 19	Year 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-1874	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Weaver				14. MOTHER'S MAIDEN NAME Martha Mayhew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr., mo., or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hugh A. Roddy-109 E. 2nd. St.-Frederick-Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> INTERVAL BETWEEN ONSET AND DEATH 3 mos. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Arteriosclerosis</i>							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>Hypertension and Chronic Nephritis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County)	(State)	
21. I certify that I attended the deceased from <i>Dec 1, 1956 to Feb 25, 1957</i> , that I last saw the deceased alive on <i>Feb 25, 1957</i> , and that death occurred at <i>1:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4 E. Church St.-Frederick-Md.</i> DATE SIGNED <i>A. A. Pearre</i>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) Dr. A. A. Pearre							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 28-57	22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery	22d. LOCATION (City, town, or county) Frederick-Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline &amp; Son</i>				24a. ADDRESS Frederick-Maryland	24b. REG'D BY REGISTRAR DATE <i>28 Feb 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heeb</i>	

1  
HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FBI BUREAU

MAR 1 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01822

## 1787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick MARYLAND		b. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick	87	Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
COLLEGE PARKWAY		College Parkway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BENJAMIN	Middle ROSENOUR	Last J
4. SEX	5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	87 yrs.
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
87 yrs.	CLOTHING RETIRED RETAIL	MD	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MASTERN NAME		
BERNHARD ROSENOUR	SARAH SEIFENSEIDER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	520-587-111	ROSE STERN	FREDERICK MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>120.1</u> DUE TO <u>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE	DATE SIGNED		
EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) (State)
BURIAL	2/12/57	HEBREW FRIENDSHIP	BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24. REC'D BY REGISTRAR
C. Farnsworth, Esq.		Frederick, Md.	DATE 11 Feb 1957
			24b. REGISTRAR'S SIGNATURE
			Elizabeth G. Heck

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
PURÉAU V. S.

FEB 10 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1815

## CERTIFICATE OF DEATH

01823

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		c. LENGTH OF STAY IN 1b <b>years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		d. STREET ADDRESS <b></b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b></b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Manie</b>	Middle <b>R.</b>	Last <b>Rudy</b>	4. DATE OF DEATH <b>2</b>	Month <b>2</b>	Day <b>15</b>	Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/1877</b>		9. AGE (In years (put birthday) yrs <b>79</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. IF UNDER 24 HRS Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>George W. Castle</b>		14. MOTHER'S MAIDEN NAME <b>Susan R. Koogler</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Edgar Castle, Middletown, Md.</b>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</b>		Causality Conclusion (Acute) <b>Generalized Arterio Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> duration					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Middletown</b>	(County) <b>Middlesex</b>	(State) <b>Md.</b>					
21. I certify that I attended the deceased from <b>Jan</b> , 1957, to <b>Feb 15</b> , 1957, that I last saw the deceased alive on <b>Feb 3</b> , 1957, and that death occurred at <b>M.</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>2-16-57</b>					
ACTUAL SIGNATURE <i>Elmer Harp</i>		PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b>		M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/17/1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Lutheran Cemetery</b>	22d. LOCATION (City, town, or county) <b>Middletown, Md.</b>		(State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co., Middletown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>18 Feb 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>					

BUREAU U. S.

1957

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1816

## CERTIFICATE OF DEATH

01824  
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b lyr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Emergency Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural --Mt. Airy	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLEN		First I Middle	4. DATE OF DEATH FEB. 10 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME David Wright		14. MOTHER'S MAIDEN NAME Joanna Shadrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	17. INFORMANT Mrs. John Weishaar, Mt. Airy, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42 d 1 DUE TO Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis DUE TO (c)		2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. n. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:55 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 7 N. Market St., Frederick, Md. DATE SIGNED 2-11-57	
ACTUAL SIGNATURE <i>H. F. Kline</i>		PHYSICIAN'S NAME (Type) H. F. Kline, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-13-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Prospect		22d. LOCATION (City, town, or county) Frederick Co., Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		24a. REC'D BY REGISTRAR DATE 14 Feb. 1957	
		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Deak</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CHIEF V. 2

TEG - 1957

REGISTRATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 014825

1708

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Jesse		First Cline	Middle Shaver
4. DATE OF DEATH Feb. 25	Month 1957	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office clerk		10b. KIND OF BUSINESS OR INDUSTRY Oil Company	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel A. Shaver		14. MOTHER'S MAIDEN NAME Carrie Propes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 214-10-5265	
17. INFORMANT No		Mrs. Jesse C. Shaver-11 N. Jefferson St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1956, to _____, 1957, that I last saw the deceased alive on _____, and that death occurred at _____ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. James B. Thomas PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION (Check one) Burial		22b. DATE THEREOF Feb. 27-1957	22c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE 27 Feb. 1957
24b. REGISTRAR'S SIGNATURE Elizabeth B. Heeb			

DUHAU Y. S

Feb 2, 1957

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1817

## CERTIFICATE OF DEATH

01826

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick		d. STREET ADDRESS 213 W. Potomac St.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John Cornelius		First	Middle	Last	4. DATE OF DEATH February	Month	Day	Year			
5. SEX Male	6. COLOR OR White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	DATE OF BIRTH Aug. 15, 1887	9. AGE (in years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Washington C. Shivers		14. MOTHER'S MAIDEN NAME Mary Henry		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Deceased		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			19. INTERVAL BETWEEN ONSET AND DEATH 2 months		
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20d. INJURY OCCURRED Month, Day, Year Hour a. m. 19 p. m.					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work <input type="checkbox"/> at work <input type="checkbox"/>	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from January 29, 1957, to February 11, 1957, that I last saw the deceased alive on February 10, 1957, and that death occurred at 6:45 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>I. B. Lyon</i>		M.D.		Cullen, Md.		ADDRESS (Street, city or town, state)			DATE SIGNED February 11, 1957		
PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-57		22c. NAME OF CEMETERY OR CREMATORIAL Park Heights		22d. LOCATION (City, town, or county) Brunswick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Lee</i>		ADDRESS Brunswick-Md		24a. REC'D BY REGISTRAR DATE 2/11/57		24b. REGISTRAR'S SIGNATURE <i>I. B. Lyon</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

3.5 V. C

1991



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1818

## CERTIFICATE OF DEATH

01827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Emmitsburg</b>		c. LENGTH OF STAY IN 1b <b>9 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Emmitsburg X</b>		d. STREET ADDRESS <b>Route # 1</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>ALICE</b>	Middle <b>ERUCE</b>	Last <b>SMITH</b>	4. DATE OF DEATH <b>February 8</b>	Month <b>1957</b>	Day <b>8</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1878</b>	9. AGE (In years lost birthday) <b>78</b>	10. IF UNDER 1 YEAR Months <b>78</b>	11. IF UNDER 24 HRS. Hours <b>00</b>	12. IF UNDER 24 HRS. Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Thurmont Fred. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Jacob Eigenbrode</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Ohler</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. J. Harry Scott, Emmitsburg, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO  <b>acute Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>		years		
DUE TO  <b>Generalized Arteriosclerosis</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Feb 5, 1957</b> to <b>Feb 8, 1957</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <b>Charles P. Williams</b>		M.D.		<b>Emmitsburg, Md</b>		<b>Feb 9, 1957</b>		
PHYSICIAN'S NAME (Type) <b>Charles P. Williams</b>				<b>Emmitsburg, Md</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Tabor</b>		22d. LOCATION (City, town, or county) <b>Rocky Ridge, Fred. Co. Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. George</b>		ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR <b>FFB 13 57</b>		24b. REGISTRAR'S SIGNATURE <b>Albrecht</b>		

MEGELVÉ  
2001. 1. 1.

8. A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1789

## CERTIFICATE OF DEATH

Reg. Dist. No. 91828

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FRED. MEM.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy, Md.</b>			
d. STREET ADDRESS <b>RURAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBIN</b>		First <b>O</b>	Middle <b>SMITH</b>		
4. DATE OF DEATH <b>2 15 1957</b>	Month <b>2</b>	Day <b>15</b>	Year <b>1957</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-57</b>		
9. AGE (In years lost birthday) yrs <b>15</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Cook</b>	14. MOTHER'S MAIDEN NAME <b>Verrie Smith</b>	Address <b>Verrie Smith Mt. Airy MD.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Verrie Smith</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Dr. Hydrabut</b> DUE TO (c) <b>Pain in left colic type</b> INTERVAL BETWEEN ONSET AND DEATH <b>—</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>—</b>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>2-15-1957</b> to <b>2-15-1957</b> , that I last saw the deceased alive on <b>2-14-1957</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Fred J. Heidrich</b> M.D. ADDRESS (Street, city or town, state) <b>220 N. MARKET ST</b> DATE SIGNED <b>—</b>					
22a. BURIAL, CREMATION, OR INCINERATION (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-19-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>MT. ZION</b>	22d. LOCATION (City, town, or county) <b>CARROLL Co. MD.</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III Fred. M.D.</b>	ADDRESS <b>—</b>	24a. REC'D BY REGISTRAR <b>19 Feb 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>		

BUREAU V. S.

FEB 21 1957

REGISTRY

RECEIVED  
FEB 21 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1790

## CERTIFICATE OF DEATH

Reg. Dist. No. 014829

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 11		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 210 South Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Robert	Middle Lee	Last Soper	4. DATE OF DEATH Feb. 17	Month 1957	Doy 17	Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25-1888	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. HOURS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Augustus Soper		14. MOTHER'S MAIDEN NAME Virginia Dixon							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-1824		17. INFORMANT Mrs. Robert Lee Soper-210 S. Market St.-Frederick		Address Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 42000 (b) DUE TO (c)		Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Broncho-Pneumonia - Chronic clavicular heart disease with congestive failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County)	(State)				
21. I certify that I attended the deceased from Feb. 13, 1957, to Feb. 17, 1957, that I last saw the deceased alive on Feb. 17, 1957, and that death occurred at 2:20 P. M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Frederick, Md			
ACTUAL SIGNATURE A. A. Gearre					DATE SIGNED 2-20-57				
PHYSICIAN'S NAME (Type) C. E. Cline & Son									
22a. BURIAL, CREMATION, REMAINS (Specify) Burial	22b. DATE THEREOF Feb. 20-1957	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick-Maryland	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son	ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE 22 Feb 1957	24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BUREAU V. S.

REF 95 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1791

## CERTIFICATE OF DEATH

01830  
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>912 North Market Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>912 North Market Street</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JEANETTE</b>		First <b>LAURA</b>	Middle <b>SPENCER</b>	Last <b>SPENCER</b>	4. DATE OF DEATH <b>2-20-57</b>	Month <b>February</b>	Day <b>20</b>	Year <b>1957</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1909</b>	9. AGE (In years last birthday) <b>47</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>	13. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY: <b>USA</b>			
13. FATHER'S NAME <b>James T. Collins</b>				14. MOTHER'S MAIDEN NAME <b>Laura McGonigall</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-7933</b>		17. INFORMANT <b>Mr. Allen D. Spencer III, Frederick, Maryland</b>		912 <sup>Address</sup> North Market St., Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>142.1</b>		DUE TO <b>Mixed cell tumor of L. Parotid gland</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>(b)</b>		DUE TO <b>Generalized metastasis</b>							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/></b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20e. (City or town) (County) (State)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <b>Sept</b> , 1957, to <b>Feb 20</b> , 1957, that I last saw the deceased alive on <b>Feb 20</b> , 1957, and that death occurred at <b>11. 00 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>H. L. Falmy</b>						ADDRESS (Street, city or town, state) <b>M.D. Second St., Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. H. L. Falmy</b>		Same as above				DATE SIGNED <b>2/23/1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>25 Feb 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>			

BUREAU Y. S

EEB, 1957

REGEIY EEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1879  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01831

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 40 A</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ijamsville R.F.D.</b>			
						d. STREET ADDRESS			
								e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Chester</b>	Middle <b>Garfield</b>	Last <b>Stone Jr.</b>	4. DATE OF DEATH <b>February 19 1957</b>	Month	Day	Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>June 6, 1939</b>	9. AGE (In years last birthday) <b>17 yrs.</b>	IF UNDER 1 YEAR Month	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Chester Garfield Stone, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Clara L. Miller</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-6922</b>		17. INFORMANT <b>Chester G. Stone, Sr.-Ijamsville-Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of base of skull</b>									
DUE TO <b>824X</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Thrown from automobile which was out of control</b>									
20c. TIME OF INJURY Hour <b>8-30</b> p.m.		Month, Day, Year <b>2/19 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40 A</b>	20f. (City or town) <b>8 miles West of Frederick</b>	(County) <b>Frederick</b>	(State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED <b>February 20, 1957</b>							
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, Cremation, Removal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-22-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick - Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Cline &amp; Son</i>		ADDRESS <i>Frederick - Md.</i>		24e. REC'D BY REGISTRAR <b>Elizabeth S. Heis</b>		24f. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heis</b>			
				DATE <b>25 Feb 1957</b>					

BUREAU Y. S.

TEB - 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01832

1792

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>13 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>500 Military Road</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>500 Military Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>EVERETT</b>		(Also known as <b>Everett Rayhu Stull, Sr.</b> )		DATE OF DEATH <b>STULL, SR.</b>		Month <b>February</b>	Day <b>10</b>	Year <b>1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years (at birthday) <b>56</b> yrs.)	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>56</b>	Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electric Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>Benton Stull</b>				14. MOTHER'S MAIDEN NAME <b>Perlia Green</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-9448</b>		17. INFORMANT <b>Mrs. Grace S. Stull (Same as item #1)</b>		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial Infarct</b> <b>Coronary arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 mos.</b>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7 N. Market St., Frederick, Md.</b>		20f. (City or town) <b>Frederick</b>		(County) <b>Maryland</b>	(State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>19. Feb. 10, 1957</b> to <b>Feb. 10, 1957</b> that I last saw the deceased alive on <b>Feb. 9, 1957</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <b>M.D.</b>		DATE SIGNED <b>2-11-57</b>	
ACTUAL SIGNATURE <b>H. F. Kline</b>		PHYSICIAN'S NAME (Type) <b>H. F. Kline, M. D.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>13 Feb 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State) <b>Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>13 Feb 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>				

RECEIVED  
FEB 13 1957

BUREAU V. S.

01833

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 141

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in block in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Fredrick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i> b. COUNTY <i>Fredrick</i>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Knoxville</i>		c. LENGTH OF STAY IN b. <i>Life</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Mountain Road</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Knoxville</i>			
3. NAME OF DECEASED (Type or print) <i>Roy</i>		First <i>S.</i> Middle <i>Taulton</i>	4. DATE OF DEATH Month <i>2</i> Day <i>10</i> Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>10-12-1893</i>		
9. AGE (In years last birthday) <i>63</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>			
13. FATHER'S NAME <i>Frank A Taulton</i>		14. MOTHER'S MAIDEN NAME <i>Fannie Webber</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>WAR</i>		16. SOCIAL SECURITY NO. <i>Willard Laple 1015- BEECHFIELD, AVE, BALTO, MD.</i>			
17. INFORMANT <i>Willard Laple</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B. O. Thomas</i>		DATE SIGNED <i>3/10/57</i>			
EXAMINER'S NAME (Type) <i>B. O. THOMAS</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-12-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Reformed</i>	
22d. LOCATION (City, town, or county) <i>Knoxville</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Brunswick, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>2/14/57</i>	
24b. REGISTRAR'S SIGNATURE <i>Eugenia Burke</i>					

1957

1957



1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01834

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural</b>		b. COUNTY <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Jefferson</b>		d. STREET ADDRESS <b>Near Jefferson</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS LAKIN THRASHER</b>		First	Middle
4. DATE OF DEATH <b>February 8, 1957</b>		Year	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Aug 1894</b>
9. AGE (in years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Thomas S. Thrasher</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Lakin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs. Della S. Thrasher (Same as item #1)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Homologe, crushed right</b>			
DUE TO (b) <b>of chest - Right arm torn from</b>			
DUE TO (c) <b>Joint - Compound fracture of arm</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Right arm caught in power tractor</b>	
20c. TIME OF INJURY Hour <b>10:30</b> a. m. Month, Day, Year <b>Feb. 8 1957</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home farm</b>
20f. (City or town) <b>Jefferson</b>		(County) <b>Frederick</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>9 Feb 1957</b>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12 Feb 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>
22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	
		24a. REC'D BY REGISTRAR <b>Eliz. S. Heck</b>	
		DATE <b>11 Feb 1957</b>	
VS. A15ME(5) 5M 9/55		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

1 FEB 19 1957

REGELVAG

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1822

## CERTIFICATE OF DEATH

Reg. Dist. No. 93

91835

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middletown</i>		c. LENGTH OF STAY IN 1b <i>years</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission), a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middletown</i>		d. STREET ADDRESS <i></i>				
3. NAME OF DECEASED (Type or print) <i>John</i>		First	Middle	Last	4. DATE OF DEATH <i>2</i>	Month	Day	Year		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-2-1880</i>	9. AGE (in years last birthday) <i>76</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>	13. IF UNDER 24 HRS Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				
13. FATHER'S NAME <i>James A. Van Ness</i>		14. MOTHER'S MAIDEN NAME <i>Mollie Hamilton</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i></i>		16. SOCIAL SECURITY NO. <i>703-16-1299</i>				17. INFORMANT <i>Mrs. Ruth Van Ness, Middletown, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH <i>17 days</i>								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO  (c)		Cerebral Hemorrhage  Generalized Arterio-Sclerosis.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>	
21. I certify that I attended the deceased from <i>Jan 21, 1957</i> , to <i>Feb 8, 1957</i> , that I last saw the deceased alive on <i>Feb 7, 1957</i> , and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above.  ACTUAL SIGNATURE <i>Elmer Harp</i>		M.D. <i></i>				ADDRESS (Street, city or town, state) <i>Middletown</i>				DATE SIGNED <i>2-9-57</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-10-1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Reformed Cemetery</i>		22d. LOCATION (City, town, or county) <i>Middletown</i>		(State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer Harp</i>		ADDRESS <i>Middletown Md</i>		24a. REC'D BY REGISTRAR DATE <i>11 Feb 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth B. Heck</i>				

PHOTO BY A. S.  
REGISTRATION  
FEB 13 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 this page should be detached for use as the Burial Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16 F. 1, 2, 4, 6-16-57 et

01836

1823

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Leon P.F. Vauthier		4. DATE OF DEATH Feb. 19th 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10-1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Episcopal church	11. BIRTHPLACE (State or foreign country) France
13. FATHER'S NAME David G. Vauthier		14. MOTHER'S MAIDEN NAME Catherine Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)		16. SOCIAL SECURITY NO. 220-34-08684	17. INFORMANT David W. Vauthier-207 S. Wickham Rd.-Balto.Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of kidney		INTERVAL BETWEEN ONSET AND DEATH 5 months	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <i>James B. Thomas</i>	M.D. Professional Bldg.-Frederick-Md. 2-21-57		
PHYSICIAN'S NAME (Type) Dr. James B. Thomas			
22a. BURIAL, Cremation, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 22-1957	22c. NAME OF CEMETERY OR CREMATORIAL St. Stephens Church Cem.	22d. LOCATION (City, town, or county) Millersville-Anne Arundel-Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>C E Cline &amp; Son</i>		ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE 23 Feb 1957
			24b. REGISTRAR'S SIGNATURE <i>Elig. M. H. H.</i>

RECEIVED  
BUREAU V. 9

FEB 25 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1795

## CERTIFICATE OF DEATH

01837

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 16 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick		d. STREET ADDRESS 1419 West Potomac	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 West Potomac				d. STREET ADDRESS 1419 West Potomac		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earnest		First	Middle	Last	4. DATE OF DEATH Month 2	Day 12	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-1883		9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trainman		10b. KIND OF BUSINESS OR INDUSTRY B.R.R.R.R.C.O.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Andrew Wellen		14. MOTHER'S MAIDEN NAME Ella R. Lightner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mazie Wellen, Brunswick, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-8-1957 to 2-12-1957 that I last saw the deceased alive on 2-11-1957, and that death occurred at 2:45 AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) 2-12-1957							
ACTUAL SIGNATURE J. L. Fruitt		M.D.					
PHYSICIAN'S NAME (Type) J. L. Fruitt							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-14-57		22c. NAME OF CEMETERY OR CREMATORIAL Reformed		22d. LOCATION (City, town, or county) Knoxville, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. W. Furt		ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE 2/14/57		24b. REGISTRAR'S SIGNATURE Eugenia Burke	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SAU V. 8

1957

166

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01838

Reg. Dist. No.

139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>30 years</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Md</b>							
d. STREET ADDRESS				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF <b>Joseph</b> (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 26, 1885</b>	9. AGE (In years last birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
13. FATHER'S NAME <b>Albert Leroy Hierman</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Virginia Feser</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-16-0836</b>		17. INFORMANT <b>John Amathia Bendoff</b>		Address <b>Salisbury, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour <b>a. m.</b> <b>p. m.</b>		Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <b>B.C. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							DATE SIGNED <b>February 22-57</b>		
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Blue Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Frederick, Md</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hallie J. George, Hagerstown, Pa.</b>		ADDRESS <b>112 B. St. 1957</b>		24a. REC'D. BY REGISTRAR DATE <b>Feb 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. J. B. Lyon</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the remains, prior to burial, cremation, or removal.

RECEIVED  
BUREAU V. S.

FEB 25 1967

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01839

131

1825

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALKERSVILLE</b>		c. LENGTH OF STAY IN 1b <b>MINUTES</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>KEYMAR XI RURHL</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM R. WILHELM</b>		First <b>WILLIAM</b>	Middle <b>R.</b>
4. DATE OF DEATH <b>FEB 25</b>	Month <b>FEB</b>	Day <b>25</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 9-1873</b>
9. AGE (in years last birthday) <b>83</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER - RETIRED OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>PETER F. WILHELM</b>		14. MOTHER'S MAIDEN NAME <b>MARY MORROW</b>	
15. WAS DECEASED EVER IN THE ARMED FORCES? <b>YES</b>		16. SOCIAL SECURITY NO. <b>205-16-3315</b>	
17. INFORMANT <b>Mrs MARY WILHELM, KEYMAR MD</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema, diverticulum</b>	
19. WAS AUTOPSY PERFORMED? <b>NO</b>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>ADDRESS (Street, city or town, state)</b>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20c. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 May</b> , 19 <b>49</b> , to <b>25 Feb</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>25 Feb</b> , 19 <b>57</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DATE SIGNED</b> <b>ACTUAL SIGNATURE</b> <i>James E. Stoner, Jr.</i> <b>M.D.</b> <b>25 Feb. 57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/28/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>MT. ZION CEM.</b>		22d. LOCATION (City, town, or county) <b>FREELAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. O. Hartzler &amp; Sons, Elsinore Bridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>27 Feb. 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>			

CERTIFICATE OF RECEIPT

SUREAU V. S

FEB 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01840

Reg. Dist. No. 138

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#6</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Bartonsville</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Frederick-Rural-R.D. #6</b>	
3. NAME OF -DECEASED (Type or print) <b>J. LLOYD</b>		4. DATE OF DEATH <b>February 17, 1957</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>1909</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. AGE (In years at birthday) <b>50</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cattle Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Livestock</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles E. Wilhise</b>		14. MOTHER'S MAIDEN NAME <b>Martha Eyler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mr. Ernest C. Wilhise, 12 East 14th Street Frederick, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <i>coronary occlusion</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>		DUE TO <b>(c)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas Sr.</b>		DATE SIGNED <b>Feb. 19, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 20, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>United Brethren Cemetery</b>		22d. LOCATION (City, town, or county) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 2-18-57</b>	
		24b. REGISTRAR'S SIGNATURE <i>Lucas K. Johnson</i>	

RECEIVED  
BUREAU Y. S.

FEB 21 1957